

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-023047

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **378** Primary Registration District No. **4552** Registrar's No. **22**

VS 300
Rev. 4/59

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Wright DIED MAY 27 1963		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Wright	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mtn. Grove, Mo.		c. CITY OR TOWN Mtn. Grove, Mo.	
Length of stay in 1b 5 yr.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Oakland Ave.		d. STREET ADDRESS (If outside, give location) Oakland Ave.	
3. NAME OF DECEASED (Type or print) First Florence Middle Smith Last Smith		4. DATE OF DEATH Month April Day 10 Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/10/1890
9. AGE (last birthday) 72		10. IF UNDER 1 YEAR Months 72 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (City and state or country) Wright Co., Mo.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Mose Coday	
13b. MOTHER'S MAIDEN NAME Mary Rhoe		14. NAME OF HUSBAND OR WIFE Sam G. Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 3	
17. INFORMANT Sam G. Smith		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) Bilateral Bronchiectatic with Infiltration Throughout Both Lung Fields DUE TO (c) UNKNOWN CAUSE			INTERVAL BETWEEN ONSET AND DEATH 4 hours 8 months undetermined
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour 9-10 a.m. 10 p.m.	Month, Day, Year 9-26-62	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 9-26-62		20f. CITY, TOWN, OR LOCATION 4-9-63	
20g. COUNTY 4-9-63		20h. STATE 4-9-63	
21. I attended the deceased from 9-26-62 to 4-9-63 and last saw her alive on 4-9-63 Death occurred at 2:10 AM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Richard M. Metcalf		22b. ADDRESS 20 Mtn Grove Mo	
22c. DATE SIGNED 4-15-63		22d. SIGNATURE Bernice P. Silberman	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-12-63	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION (City, town, or county) Mtn. Grove, Mo.	
24. FUNERAL DIRECTOR Ewell C. Craig		25. DATE RECD. BY LOCAL REG. 4-19-1963	
ADDRESS Mtn. Grove, Mo.		26. REGISTRAR'S SIGNATURE Bernice P. Silberman	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

876

MAY 28 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Lowell C. Corang

Licensed Embalmer No. 4766

P. O. Address Wm Grove

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

9-22-63 2281-5